HFP Statute

INSURANCE CODE
SECTIONS 12693-12693.99

12693. The Legislature declares all of the following:
(a) Approximately 1.6 million California children, 17 percent of children ages 17 and under, have no health insurance. One in four California children, which is 2.3 million, rely on Medi-Cal for insurance coverage, while just over half of the state's children, 53 percent, have employment-based coverage through a parent.
(b) Most uninsured California children come from low-income families, with nearly 75 percent of uninsured children (1.2 million) living in families with incomes below 200 percent of the federal poverty level. Children whose families earn incomes between 100 and 200 percent of the federal poverty level, an estimated 580,000 children, are among the most vulnerable of populations. Their families make too much money to generally qualify for free Medi-Cal, are employed in working class jobs that typically do not offer insurance, and cannot afford private health insurance. In short, affordability remains a major barrier to obtaining coverage.
(c) Notwithstanding the generally good health of children, health insurance coverage is important to ensure that they receive the health care that is essential to monitor their growth, nutrition, and development and to address potential health problems early.
(d) Lack of insurance coverage for children results in reduced access to medical services, resulting in restricted access to primary and preventive care and increased reliance on emergency rooms and hospitals for treatment. Timely treatment for infectious and chronic diseases can prevent more serious medical conditions in children of all ages.
(e) When a child is seriously ill or injured, the costs of needed medical care can force families into financial ruin.
(f) That by July 1, 1998, there shall be in place a program providing access to health coverage to all children residing in households with family incomes below 200 percent of the federal poverty level.
(g) It is the intent of the Legislature that the program comply with the requirements of Title XXI of the Social Security Act, also know as the State Children's Health Insurance Program.

12693.01. For purposes of this part, the definitions contained in this chapter shall govern the construction of this part, unless the context requires otherwise.

12693.02. (a) "Applicant" means a person over the age of 18 years who is a natural or adoptive parent; a legal guardian; or a caretaker relative, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child.

(b) "Applicant" also means any of the following:

(1) A person 18 years of age who is applying on his or her own behalf for coverage under the program.

(2) A person who is under 18 years of age and is an emancipated minor who is applying on his or her own behalf for coverage under the program.

(3) A minor who is not living in the home of a natural or adoptive parent, a legal guardian, or a caretaker relative, foster parent or stepparent, who is applying on his or her own behalf for coverage under the program.

(4) A minor who applies for coverage under the program on behalf of his or her child.

12693.03. "Board" means the Managed Risk Medical Insurance Board.

12693.04. "Child" means a person who is under 19 years of age who is eligible for the program pursuant to Chapter 9 (commencing with Section 12693.70).

12693.045. "Community provider plan" means that participating health plan in each geographic area that has been designated by the board as having the highest percentage of traditional and safety net providers in its provider network.

12693.05. "County organized health system" means a health care organization that contracts with the State Department of Health Services to provide comprehensive health care to all eligible Medi-Cal beneficiaries residing in the county, and that is operated directly by a public entity established by a county government pursuant to Section 14087.51 or 14087.54 of the Welfare and Institutions Code, or Chapter 3 (commencing with Section 101675) of Part 4 of Division 101 of the Health and Safety Code.

12693.06. "Family contribution" means the cost to an applicant to enable herself or himself or an eligible child or children to enroll in and participate in the program. Family contribution does not include copayments for insured services. The family contribution may be paid by a family contribution sponsor pursuant to Section 12693.17.

12693.065. "Family value package" means the combination of participating health, dental, and vision plans available to subscribers in each geographic area offering the lowest prices to the program. The board may define the family value package to include not only the combination of participating health, dental, and vision plans offering the absolute lowest price to the program but also the combination of health, dental, and vision plans within a fixed percentage or dollar amount of the absolute lowest price.

12693.07. "Fund" means the Healthy Families Fund.

12693.08. "Local initiative" means a prepaid health plan that is organized by, or designated by, a county government or county governments, or organized by stakeholders, of a region designated by the department to provide comprehensive health care to eligible Medi-Cal beneficiaries. The entities established pursuant to the following sections of the Welfare and Institutions Code are local initiatives: Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96.

12693.09. "Participating dental plan" means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal dental services under insurance policies or contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contract with the board to provide coverage to program subscribers:

(a) A dental insurer holding a valid outstanding certificate of authority from the commissioner.

(b) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

12693.10. "Participating health plan" means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the board to provide coverage to program subscribers:

(a) A private health insurer holding a valid outstanding certificate of authority from the commissioner.

(b) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.

(c) A county organized health system.

(d) A local initiative.

12693.105. A health care service plan, as defined in subdivision (b) of Section 12693.10, shall include a plan operating as a geographic managed care plan.

12693.11. "Participating vision care plan" means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal vision services under insurance policies or contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contract with the board to provide coverage to program subscribers:

(a) A vision insurer holding a valid outstanding certificate of authority from the commissioner.

(b) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

12693.12. "Program" means the Healthy Families Program, which includes a purchasing pool providing health coverage for children in families without access to affordable employer based dependent coverage and a purchasing credit mechanism through which families with access to employer based dependent coverage can receive financial assistance with the cost of dependent coverage for children.

12693.13. "Purchasing credit member" means an applicant 18 years of age or a child who is eligible for and participates in the purchasing credit component of the program.

12693.14. "Subscriber" means an applicant 18 years of age or a child who is eligible for and participates in the purchasing pool component of the program.

12693.15. "Supplemental coverage" means coverage purchased by the program from (a) a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner, or (b) a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code to bring the coverage available to purchasing credit members into at least 95 percent actuarial equivalence with the coverage provided to subscribers through the purchasing pool component of the program. The coverage shall provide for any necessary adjustment of the cost-sharing levels charged to purchasing credit members to be equivalent to those charged to subscribers through the purchasing pool component of the program. Subscriber costs and benefits for the purchasing credit members shall

be at least 95 percent actuarially equivalent to subscriber costs and benefits in the purchasing pool component.

12693.16. "Geographic managed care plan" means an entity that is operating pursuant to a contract entered into under Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

12693.17. "Family contribution sponsor" means a person or entity that pays the family contribution on behalf of an applicant for any period of 12 consecutive months and, notwithstanding Section 12693.70, if the sponsor is paying for the initial 12 months of eligibility, the payment for 12 months is made with the application.

12693.20. The Healthy Families Program is hereby created and shall be administered by the Managed Risk Medical Insurance Board.

12693.21. The board may do all of the following consistent with the standards in this part:

(a) Determine eligibility criteria for the program.

(b) Determine the participation requirements of applicants, subscribers, purchasing credit members, and participating health, dental, and vision plans.

(c) Determine when subscribers' coverage begins and the extent and scope of coverage.

(d) Determine family contribution amount schedules and collect the contributions.

(e) Determine who may be a family contribution sponsor and provide a mechanism for sponsorship.

(f) Provide or make available subsidized coverage through participating health, dental, and vision plans, in a purchasing pool, which may include the use of a purchasing credit mechanism, through supplemental coverage, or through coordination with other state programs.

(g) Provide for the processing of applications, the enrollment of subscribers, and the distribution of purchasing credits.

(h) Determine and approve the benefit designs and copayments required by health, dental, or vision plans participating in the purchasing pool component program.

(i) Approve those health plans eligible to receive purchasing credits.

(j) Enter into contracts.

(k) Sue and be sued.

(l) Employ necessary staff.

(m) Authorize expenditures from the fund to pay program expenses that exceed subscriber contributions, and to administer the program as necessary.

(n) Maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available in the Healthy Families Fund and if sufficient funds are not available to cover the estimated cost of program expenditures, the board shall institute appropriate measures to limit enrollment.

(o) Issue rules and regulations, as necessary. Until January 1, 2000, any rules and regulations issued pursuant to this subdivision may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.

(p) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part.

purchasing credits, supplemental coverage, or other means as appropriate to meet the purposes of this part.

12693.26. The board shall establish a purchasing pool for coverage of program subscribers to enable applicants without access to affordable and comprehensive employer-sponsored dependent coverage to provide their eligible children with health, dental, and vision benefits. The board shall negotiate separate contracts with participating health, dental, and vision plans for each of the benefit packages described in Chapters 5 (commencing with Section 12693.60), 6 (commencing with Section 12693.63), and 7 (commencing with Section 12693.65).

12693.27. (a) The board shall develop a purchasing credit mechanism to enable applicants with access to affordable and comprehensive employer-sponsored dependent coverage to have an eligible child enrolled in the employer's health plan. Children enrolled in the purchasing credit mechanism may receive dental and vision benefits through the purchasing pool component of the program.

(b) In order to be eligible for a purchasing credit, the employer shall make a meaningful contribution toward the cost of coverage for an employee's dependents for whom an application is made for a purchasing credit. An employer's contribution, including any increases or decreases in the contribution made after the effective date of this part, may not vary among employees based on wage base or job classification.

(c) The board shall adopt appropriate mechanisms to recoup purchasing credit expenditures from an employer plan when the employees or dependents on behalf of whose coverage the payments are made are no longer enrolled in that plan.

(d) An employer utilizing a purchasing credit arrangement and a participating health plan receiving a purchasing credit must use 100 percent of the funds for the purchase of coverage for purchasing

credit members including dependent coverage.

(e) A participating plan shall not assess the board for any portion of late fees, returned checks, or other fees in connection with an employer with group coverage who is also participating in the purchasing credit arrangement.

(f) An applicant may begin coverage for dependents using a purchasing credit arrangement at any time. Purchasing credit members enrolling in employer-sponsored coverage shall not be considered late enrollees for the purposes of subdivision (d) of Section 1357 and subdivision (b) of Section 1357.50 of the Health and Safety Code, and subdivision (b) of Section 10198.6 and subdivision (l) of Section 10700.

(g) Under no circumstances shall the employee's share of cost, including, deductibles, copayments, and coinsurance, for dependent coverage, including any supplemental coverage necessary to meet the 95 percent actuarial standard established in Section 12693.15 be more than that required as the employee's share of premium if the employee's children were enrolled in the purchasing pool component of the program.

(h) The board may limit participation in the purchasing credit program to those employers that provide employee health benefits through participation in public or private purchasing cooperatives.

12693.28. The program shall be administered without regard to gender, race, creed, color, sexual orientation, health status, disability, or occupation.

12693.29. (a) The board shall use appropriate and efficient means to notify families of the availability of health coverage from the program.

(b) The State Department of Health Services in conjunction with the board shall conduct a community outreach and education campaign in accordance with Section 14067 of the Welfare and Institutions Code to assist in notifying families of the availability of health coverage for their children.

(c) The board shall use appropriate materials, which may include brochures, pamphlets, fliers, posters, and other promotional items, to notify families of the availability of coverage through the program.

12693.30. (a) The board shall assure that written enrollment information issued or provided by the program is available to program subscribers and applicants in each of the languages identified pursuant to Chapter 17.5 (commencing with Section 7290) of Division 7 of Title 1 of the Government Code.

(b) The board shall assure that phone services provided to program

subscribers and applicants by the program are available in all of the languages identified pursuant to Chapter 17.5 (commencing with Sec. 7290) of Division 7 of Title 1 of the Government Code.

(c) The board shall assure that interpreter services are available between subscribers and contracting plans. The board shall assure that subscribers are provided information within provider network directories of available linguistically diverse providers.

(d) The board shall assure that participating health, dental, and vision plans provide documentation on how they provide linguistically and culturally appropriate services, including marketing materials, to subscribers.

12693.31. No participating health, dental, or vision plan shall, in an area served by the program, directly, or through an employee, agent, or contractor, provide an applicant, or a child with any marketing material relating to benefits or rates provided under the program unless the material has been both reviewed and approved by the board.

12693.32. (a) The board may pay designated individuals or organizations an application assistance fee, if the individual or organization assists an applicant to complete the program application, and the applicant is enrolled in the program as a result of the application.

(b) The board may establish the list of eligible individuals, or categories of individuals and organizations, the amount of the application assistance payment, and rules necessary to assure the integrity of the payment process.

(c) The board, as part of its community outreach and education campaign, may include community-based face-to-face initiatives to educate potentially eligible applicants about the program and to assist potential applicants in the application process. Those entities undertaking outreach efforts shall not include as part of their responsibilities the selection of a health plan and provider for the applicant. Participating plans shall be prohibited from directly, indirectly, or through their agents conducting in-person, door-to-door, mail, or telephone solicitation of applicants for enrollment except through employers with employees eligible to participate in the purchasing credit mechanism. However, information approved by the board on the providers and plans available to prospective subscribers in their geographic areas shall be distributed through any door-to-door activities for potentially eligible applicants and their children.

(d) (1) All assistance offered to an individual applying to the program shall be free of charge. Except as provided in subdivision (a) or by a regulation adopted by the board, no individual or

organization offering or providing assistance to an applicant to complete the program application shall solicit or receive any fee or remuneration from the applicant or subscriber for offering or providing that service.

(2) A person who violates this subdivision or a regulation adopted by the board pursuant to this subdivision, shall be assessed a civil penalty of five hundred dollars ($500) for each violation. For this purpose, a violation occurs each day a solicitation is published on an Internet Web site or is otherwise circulated to the public. This penalty is in addition to any other remedy or penalty provided by law. All penalties collected under this paragraph shall be deposited in the State Treasury to the credit of the Healthy Families Fund.

(3) A civil or administrative action brought under this article at the request of the board may be brought by the Attorney General in the name of the people of the State of California in a court of competent jurisdiction, or in a hearing through the Office of Administrative Hearings conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that when a civil action is to be filed in small claims court, the board may bring the action. The action shall be filed within three years of the date the board discovered the facts indicating a violation of this subdivision.

12693.325. (a) (1) Notwithstanding any provision of this chapter, a participating health, dental, or vision plan that is licensed and in good standing as required by subdivision (b) of Section 12693.36 may provide application assistance directly to an applicant acting on behalf of an eligible person who telephones, writes, or contacts the plan in person at the plan's place of business, or at a community public awareness event that is open to all participating plans in the county, or at any other site approved by the board, and who requests application assistance.

(2) A participating health, dental, or vision plan may also provide application assistance directly to an applicant only under the following conditions:

(A) The assistance is provided upon referral from a government agency, school, or school district.

(B) The applicant has authorized the government agency, school, or school district to allow a health, dental, or vision plan to contact the applicant with additional information on enrolling in free or low-cost health care.

(C) The State Department of Health Services approves the applicant authorization form in consultation with the board.

(D) The plan may not actively solicit referrals and may not provide compensation for the referrals.

(E) If a family is already enrolled in a health plan, the plan

that contacts the family cannot encourage the family to change health plans.

(F) The board amends its marketing guidelines to require that when a government agency, school, or school district requests assistance from a participating health, dental, or vision plan to provide application assistance, that all plans in the area shall be invited to participate.

(G) The plan abides by the board's marketing guidelines.

(b) A participating health, dental, or vision plan may provide application assistance to an applicant who is acting on behalf of an eligible or potentially eligible child in any of the following situations:

(1) The child is enrolled in a Medi-Cal managed care plan and the participating plan becomes aware that the child's eligibility status has or will change and that the child will no longer be eligible for Medi-Cal. In those instances, the plan shall inform the applicant of the differences in benefits and requirements between the Healthy Families Program and the Medi-Cal program.

(2) The child is enrolled in a Healthy Families Program managed care plan and the participating plan becomes aware that the child's eligibility status has changed or will change and that the child will no longer be eligible for the Healthy Families Program. When it appears a child may be eligible for Medi-Cal benefits, the plan shall inform the applicant of the differences in benefits and requirements between the Medi-Cal program and the Healthy Families Program.

(3) The participating plan provides employer-sponsored coverage through an employer and an employee of that employer who is the parent or legal guardian of the eligible or potentially eligible child.

(4) The child and his or her family are participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.

(5) The child's family, but not the child, is participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law, and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.

(c) A participating health, dental, or vision plan employee or other representative that provides application assistance shall complete a certified application assistant training class approved by the State Department of Health Services in consultation with the board. The employee or other representative shall in all cases inform an applicant verbally of his or her relationship with the participating health plan. In the case of an in-person contact, the

employee or other representative shall provide in writing to the applicant the nature of his or her relationship with the participating health plan and obtain written acknowledgment from the applicant that the information was provided.

(d) A participating health, dental, or vision plan that provides application assistance may not do any of the following:

(1) Directly, indirectly, or through its agents, conduct door-to-door marketing or telephone solicitation.

(2) Directly, indirectly, or through its agents, select a health plan or provider for a potential applicant. Instead, the plan shall inform a potential applicant of the choice of plans available within the applicant's county of residence and specifically name those plans and provide the most recent version of the program handbook.

(3) Directly, indirectly, or through its agents, conduct mail or in-person solicitation of applicants for enrollment, except as specified in subdivision (b), using materials approved by the board.

(e) A participating health, dental, or vision plan that provides application assistance pursuant to this section is not eligible for an application assistance fee otherwise available pursuant to Section 12693.32, and may not sponsor a person eligible for the program by paying his or her family contribution amounts or copayments, and may not offer applicants any inducements to enroll, including, but not limited to, gifts or monetary payments.

(f) A participating health, dental, or vision plan may assist applicants acting on behalf of subscribers who are enrolled with the participating plan in completing the program's annual eligibility review package in order to allow those applicants to retain health care coverage.

(g) Each participating health, dental, or vision plan shall submit to the board a plan for application assistance. All scripts and materials to be used during application assistance sessions shall be approved by the board and the State Department of Health Services.

(h) Each participating health, dental, or vision plan shall provide each applicant with the toll-free telephone number for the Healthy Families Program.

(i) When deemed appropriate by the board, the board may refer a participating health, dental, or vision plan to the Department of Managed Health Care or the State Department of Health Services, as applicable, for the review or investigation of its application assistance practices.

(j) The board shall evaluate the impact of the changes required by this section and shall provide a biennial report to the Legislature on or before March 1 of every other year. To prepare these reports, the State Department of Health Services, in cooperation with the board, shall code all the application packets used by a managed care

plan to record the number of applications received that originated from managed care plans. The number of applications received that originated from managed care plans shall also be reported on the board's Web site. In addition, the board shall periodically survey those families assisted by plans to determine if the plans are meeting the requirements of this section, and if families are being given ample information about the choice of health, dental, or vision plans available to them.

(k) Nothing in this section shall be seen as mitigating a participating health, dental, or vision plan's responsibility to comply with all federal and state laws, including, but not limited to, Section 1320a-7b of Title 42 of the United States Code.

(l) Paragraph (2) of subdivision (a) shall become inoperative on January 1, 2006.

12693.326. Notwithstanding any other provision of this part, a new subscriber in the program shall be allowed to switch his or her choice of plans once within the first three months of coverage for any reason.

12693.33. To the extent feasible and permissible under federal law and with receipt of necessary federal approvals, the State Department of Health Services and the board shall develop a joint Medi-Cal and program application and enrollment form for children. The department shall seek any federal approval necessary to implement a combined application form.

12693.34. (a) The board may establish geographic areas within which participating health, dental, and vision plans may offer coverage to subscribers.

(b) Nothing in this section shall restrict a county organized health system or a local initiative from providing service to program subscribers in their licensed geographic service area.

12693.35. Participating health, dental, and vision plans shall have, but need not be limited to, all of the following operating characteristics satisfactory to the board in consultation with the plan's licensing or regulatory oversight agency:

(a) Strong financial condition, including the ability to assume the risk of providing and paying for covered services. A participating plan may utilize reinsurance, provider risk sharing, and other appropriate mechanisms to share a portion of the risk.

(b) Adequate administrative management.

(c) A satisfactory grievance procedure.

(d) Participating plans that contract with or employ health care providers shall have mechanisms to accomplish all of the following,

in a manner satisfactory to the board:
(1) Review the quality of care covered.
(2) Review the appropriateness of care covered.
(3) Provide accessible health care services.
(e) (1) Before the effective date of the contract, the participating health plan shall have devised a system for identifying in a simple and clear fashion both in its own records and in the medical records of subscribers the fact that the services provided are provided under the program.
(2) Throughout the duration of the contract, the plan shall use the system described in paragraph (1).
(f) Plans licensed by the Department of Corporations shall be deemed to meet the requirements of subdivisions (a) to (d), inclusive, of this section.

12693.36. (a) Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Health Care, as the case may be.
(b) Participating health, dental, and vision plans that contract with the program and are regulated by either the Insurance Commissioner or the Department of Managed Health Care shall be licensed and in good standing with their respective licensing agencies. In their application to the program, those entities shall provide assurance of their standing with the appropriate licensing entity.

12693.365. Geographic managed care plans that have a contract with the Department of Health Services, that contract with the program, and that are licensed by the Department of Managed Health Care but do not have a commercial license from the Department of Managed Health Care, may contract with the board for a maximum of 12 months. During this 12-month period, those plans shall be required to be in good standing with the Department of Managed Health Care and shall demonstrate to the board that they are making a good faith effort to obtain a commercial license from the Department of Managed Health Care. In their application to the program, those plans shall provide assurance of their standing with the Department of Managed Health Care and shall outline their plans for obtaining commercial licensure.

12693.37. (a) The board shall contract with a broad range of health plans in an area, if available, to ensure that subscribers have a choice from among a reasonable number and types of competing health plans. The board shall develop and make available objective criteria for health plan selection and provide adequate notice of the

application process to permit all health plans a reasonable and fair opportunity to participate. The criteria and application process shall allow participating health plans to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this chapter. Health plan selection shall be based on the criteria developed by the board.

(b) (1) In its selection of participating plans the board shall take all reasonable steps to assure the range of choices available to each applicant, other than a purchasing credit member, shall include plans that include in their provider networks and have signed contracts with traditional and safety net providers.

(2) Participating health plans shall be required to submit to the board on an annual basis a report summarizing their provider network. The report shall provide, as available, information on the provider network as it relates to:

(A) Geographic access for the subscribers.

(B) Linguistic services.

(C) The ethnic composition of providers.

(D) The number of subscribers who selected traditional and safety net providers.

(c) (1) The board shall not rely solely on the Department of Managed Health Care's determination of a health plan network's adequacy or geographic access to providers in the awarding of contracts under this part. The board shall collect and review demographic, census, and other data to provide to prospective local initiatives, health plans, or specialized health plans, as defined in this act, specific provider contracting target areas with significant numbers of uninsured children in low-income families. The board shall give priority to those plans, on a county-by-county basis, that demonstrate that they have included in their prospective plan networks significant numbers of providers in these geographic areas.

(2) Targeted contracting areas are those ZIP Codes or groups of ZIP Codes or census tracts or groups of census tracts that have a percentage of uninsured children in low-income families greater than the overall percentage of uninsured children in low-income families in that county.

(d) In each geographic area, the board shall designate a community provider plan that is the participating health plan which has the highest percentage of traditional and safety net providers in its network. Subscribers selecting such a plan shall be given a family contribution discount as described in Section 12693.43.

(e) The board shall establish reasonable limits on health plan administrative costs.

12693.38. (a) The board shall contract with a sufficient number of dental and vision plans to assure that dental and vision benefits are available to all subscribers. The board shall develop and make available objective criteria for dental and vision plan selection and provide adequate notice of the application process to permit all dental and vision plans a reasonable and fair opportunity to participate. The criteria and application process shall allow participating dental and vision plans to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this part. Dental and vision plan selection shall be based on the criteria developed by the board.

(b) Participating dental plans shall be required to submit to the board on an annual basis a report summarizing their provider network. The report shall provide, as available, information on the provider network as it relates to each of the following:

(1) Geographic access for the subscribers.

(2) Linguistic services.

(3) The ethnic composition of providers.

(c) The board shall establish reasonable limits on dental plan administrative costs.

12693.39. The board shall establish a process for determining which employer-sponsored health plans are eligible to receive a purchasing credit issued by the program. The process shall assure that the benefits, copayments, coinsurance, and deductibles are no less than 95 percent actuarially equivalent to those provided to program subscribers enrolled in the purchasing pool.

12693.40. The board shall contract with health plans to provide coverage supplemental to that provided by an applicant's or applicant' s spouse's employer-sponsored health plan for the purchasing credit member, if the employer-sponsored plan's benefits are not 95 percent actuarially equivalent to those provided to subscribers. If supplemental coverage is available and provided, the plan may then, notwithstanding Section 12693.39, become eligible to receive purchasing credits.

12693.41. (a) The board shall consult and coordinate with the State Department of Health Services in implementing a preenrollment program into the Healthy Families Program or the Medi-Cal program pursuant to subdivision (b) of Section 14011.7 of the Welfare and Institutions Code. The board shall accept the followup application provided for in Section 14011.7 of the Welfare and Institutions Code as an application for the Healthy Families Program. Preenrollment shall be administered by the State Department of Health Services to

provide full-scope benefits pursuant to Medi-Cal program requirements, at no cost to the applicant.

(b) The board may use the state fiscal intermediary for medicaid to process the eligibility determinations and payments required pursuant to Section 14011.7 of the Welfare and Institutions Code.

(c) The board shall be exempt from the requirements of Chapter 7 (commencing with Section 11700) of Division 3 of Title 2 of the Government Code and Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code as those requirements apply to the use of processing services by the state fiscal intermediary.

(d) The board may adopt emergency regulations to implement preenrollment into the Healthy Families Program or the Medi-Cal program pursuant to Section 14011.7 of the Welfare and Institutions Code. The emergency regulations shall include, but not be limited to, regulations that implement any changes in rules relating to eligibility, enrollment, and disenrollment in the programs pursuant to Sections 12693.45 and 12693.70. The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and one readoption of those regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and each shall remain in effect for no more than 180 days.

(e) This section shall become operative on April 1, 2003.

12693.42. Any purchasing credit issued by the board, or a contractor acting on behalf of the board, pursuant to this part shall have an overall cost to the program no greater than the cost to the program to enroll the subscriber in the lowest cost plan available to the subscriber through the purchasing pool. Administrative costs and the cost to the program of any supplemental product shall be included in the calculation of the cost of the purchasing credit program and deducted from the amount of the purchasing credit.

12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions, unless the applicant has a family contribution sponsor. Family contribution amounts consist of the following two components:

(1) The flat fees described in subdivision (b) or (d).

(2) Any amounts that are charged to the program by participating

health, dental, and vision plans selected by the applicant that exceed the cost to the program of the highest cost Family Value Package in a given geographic area.

(b) In each geographic area, the board shall designate one or more Family Value Packages for which the required total family contribution is:

(1) Seven dollars ($7) per child with a maximum required contribution of fourteen dollars ($14) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Nine dollars ($9) per child with a maximum required contribution of twenty-seven dollars ($27) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(3) On and after July 1, 2005, fifteen dollars ($15) per child with a maximum required contribution of forty-five dollars ($45) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this subparagraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this subparagraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(c) Combinations of health, dental, and vision plans that are more expensive to the program than the highest cost Family Value Package may be offered to and selected by applicants. However, the cost to the program of those combinations that exceeds the price to the program of the highest cost Family Value Package shall be paid by the applicant as part of the family contribution.

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area that has been designated as the Community Provider Plan. The discount shall reduce the portion of the family contribution described in subdivision (b) to the following:

(1) A family contribution of four dollars ($4) per child with a maximum required contribution of eight dollars ($8) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Six dollars ($6) per child with a maximum required contribution of eighteen dollars ($18) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(3) On and after July 1, 2005, twelve dollars ($12) per child with a maximum required contribution of thirty-six dollars ($36) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this subparagraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this subparagraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(e) Applicants, but not family contribution sponsors, who pay three months of required family contributions in advance shall receive the fourth consecutive month of coverage with no family contribution required.

(f) Applicants, but not family contribution sponsors, who pay the required family contributions by an approved means of electronic fund transfer shall receive a 25-percent discount from the required family contributions.

(g) It is the intent of the Legislature that the family contribution amounts described in this section comply with the premium cost sharing limits contained in Section 2103 of Title XXI of the Social Security Act. If the amounts described in subdivision (a) are not approved by the federal government, the board may adjust these amounts to the extent required to achieve approval of the state plan.

(h) The adoption and one readoption of regulations to implement paragraph (3) of subdivision (b) and paragraph (3) of subdivision (d)

shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health, and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe specific facts showing the need for immediate action and from review by the Office of Administrative Law. For purpose of subdivision (e) of Section 11346.1 of the Government code, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative law, is hereby extended to 180 days.

12693.44. (a) The board shall establish family contribution amounts for purchasing credit members that are equivalent to the amounts charged to subscribers participating in the purchasing pool portion of the program. Purchasing credit members shall not be required to pay family contribution amounts greater than the cost to the applicant if the purchasing credit members were enrolled in the purchasing pool component of the program. When calculating the cost to the applicant to participate in the purchasing pool, the family contribution discounts provided in subdivisions (c), (d), and (e) of Section 12693.34 shall not be considered. Purchasing credit members shall be eligible for dental and vision coverage through the purchasing pool at no additional premium charge.

(b) The family contribution amounts paid on behalf of a purchasing credit member may be paid directly to the applicant's employer through a payroll deduction or other mechanism.

12693.45. (a) After two consecutive months of nonpayment of family contributions by an applicant, and a reasonable written notice period of no less than 30 days is provided to the applicant, subscribers or purchasing credit members may be disenrolled for an applicant's failure to pay family contributions. The board may impose or contract for collection actions to collect unpaid family contributions.

(b) Subject to any additional requirements of federal law, disenrollments shall be effective at the end of the second consecutive month of nonpayment.

12693.46. The board may prohibit applicants who drop coverage after enrolling in the pool from reenrollment in the program for up to six months.

12693.47. The program may place a lien on compensation or benefits, recovered or recoverable by a subscriber or applicant from any party or parties responsible for the compensation or benefits for which benefits have been provided under a policy issued under this part.

12693.48. The board may adjust payments made to a participating health plan if the board finds that the plan has a significantly disproportionate share of high- or low-risk subscribers. Prior to making this finding, the program shall obtain validated data from participating health plans. Reporting requirements shall be administratively compatible with the methods of operation of the health plans. Any adjustments to payments shall utilize demographic and other factors which are actuarially related to risk.

12693.49. (a) When an applicant is dissatisfied with any action or inaction of a participating plan in which a subscriber is enrolled through the purchasing pool, the applicant shall first attempt to resolve the dispute with the participating plan according to its established policies and procedures.

(b) The board shall assure that all participating health, dental, and vision plans make subscribers aware of the regulatory oversight available to the applicant by the participating health, dental, or vision plan's licensing or state oversight entity.

(c) The board shall assure that all participating health, dental, and vision plans report to the board, at least once a year, the number and types of benefit grievances filed by applicants on behalf of subscribers in the program. This information shall be available to applicants upon request in a format determined by the board.

12693.50. (a) The board shall consult and coordinate with the State Department of Health Services to implement the Medi-Cal to Healthy Families Accelerated Enrollment program pursuant to Section 14011.65 of the Welfare and Institutions Code.

(b) The state shall seek approval of any amendments to the state plan, necessary to implement Section 14011.65 of the Welfare and Institutions Code in accordance with Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.). Notwithstanding any other provision of law, only when all necessary federal approvals have been obtained shall Section 14011.65 of the Welfare and Institutions Code be implemented.

(c) The board may adopt emergency regulations to implement the provision of accelerated eligibility benefits pursuant to this section and as described under Section 14011.65 of the Welfare and Institutions Code. The emergency regulations shall include, but not be limited to, regulations that implement any changes in rules relating to program eligibility, enrollment, and disenrollment. The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by

the Office of Administrative Law. The initial emergency regulations and one readoption of those regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations, and each shall remain in effect for no more than 180 days.

12693.51. (a) A transfer of enrollment from one participating health plan to another may be made by a subscriber at times and under conditions as may be prescribed by regulations of the board.

(b) The board shall provide for the transfer of coverage of any subscriber to another participating plan (1) if a contract with any participating plan under which the subscriber receives coverage is canceled or not renewed and (2) at least once a year upon request in a manner as determined by the board, and (3) if a subscriber moves to an area that the current health plan does not serve.

12693.515. (a) Effective July 1, 2004, any subscriber who affirmatively selects, or is assigned by default to, a federally qualified health center, as defined by Section 1396(d)(l)(2) of Title 42 of the United States Code, a rural health clinic, as defined by Section 1396(d)(l)(1) of Title 42 of the United States Code, or a primary care clinic that is licensed under Section 1204 of the Health and Safety Code, or is exempt from licensure under subdivision (h) of Section 1206 of the Health and Safety Code, shall be deemed to have been assigned directly to the federally qualified health center, the rural health clinic, or the primary care clinic, and not to any individual provider who performs services on behalf of the federally qualified health center, the rural health clinic, or the primary care clinic.

(b) (1) When a subscriber is assigned, from any source, to a physician who is an employee of a federally qualified health center, a rural health clinic, or a primary care clinic, the assignment shall constitute an assignment to that federally qualified health center, rural health clinic, or primary care clinic for purposes of the subscriber's health care coverage.

(2) When a subscriber is assigned, from any source, to a dentist who is an employee of a federally qualified health center, a rural health clinic, or a primary care clinic, the assignment shall constitute an assignment to that federally qualified health center, rural health clinic, or primary care clinic for purposes of the subscriber's dental coverage.

(3) When a subscriber is assigned, from any source, to an optometrist who is an employee of a federally qualified health center, a rural health clinic, or a primary care clinic, the assignment shall constitute an assignment to that federally qualified

health center, rural health clinic, or primary care clinic for purposes of the subscriber's vision coverage.

(c) This section shall not limit any rights a subscriber may have to select an available primary care physician within a health care service plan's service area pursuant to Section 1373.3 of the Health and Safety Code.

12693.52. The board may negotiate or arrange for stop-loss insurance coverage that limits the program's fiscal responsibility for the total costs of health services provided to program subscribers, or arrange for participating health plans to share or assure the financial risk for a portion of the total cost of health care services to program subscribers, or both.

12693.53. The board shall develop and utilize appropriate cost containment measures to maximize the coverage offered under the program. Those measures may include limiting the expenditure of state funds for this purpose to the price to the state for the lowest cost plan contracting with the program and creation of program rules that restrict the ability of employers or applicants to drop existing coverage in order to qualify children for the program.

12693.54. A contract entered pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The board shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or actual subscriber enrollments to a total amount not to exceed the amount appropriate for the program including family contributions.

12693.60. Coverage provided to subscribers shall meet the federal coverage requirements in Section 2103 of Title XXI of the Social Security Act. The covered health benefits provided to subscribers shall be equivalent to those provided to state employees through the Public Employees' Retirement System on January 1, 1998, except that the plans may provide a mechanism for inpatient hospital care provided under the mental health benefit through which applicants may agree to a treatment plan in which each inpatient day may be substituted for two residential treatment days or three day treatment program days.

12693.61. The following provisions apply for subscribers who have been identified by the participating health plans as potentially seriously emotionally disturbed.

(a) Participating plans, to the extent feasible, including plans

receiving purchasing credits shall develop memoranda of understanding, consistent with criteria established by the board in consultation with the State Department of Mental Health, for referral of subscribers who are seriously emotionally disturbed to a county mental health department. This referral does not relieve a participating plan from providing the mental health coverage specified in its contract, including assessment of, and development of, a treatment plan for serious emotional disturbance. Plans may contract with county mental health departments to provide for all, or a portion of, the services provided under the program's mental health benefit.

(b) The board shall establish an accounting process under which counties providing services to subscribers who have been determined to be seriously emotionally disturbed pursuant to Section 5600.3 of the Welfare and Institutions Code can claim federal reimbursement for the services. The board shall reimburse counties pursuant to the rates set by the State Department of Mental Health in accordance with Sections 5705, 5716, 5718, 5720, 5724, and 5778 of the Welfare and Institutions Code. The actual amount reimbursed by the board shall be the federal share of the cost of the subscriber.

(c) This section shall only become operative with federal approval of the State Child Health Plan and the approval of federal financial participation.

(d) Counties choosing to enter into a memorandum of understanding pursuant to subdivision (a) shall provide the nonfederal share of cost for the subscriber.

12693.615. (a) The board shall establish the required subscriber copayment levels for specific benefits consistent with the limitations of Section 2103 of Title XXI of the Social Security Act. The copayment levels established by the board shall, to the extent possible, reflect the copayment levels established for state employees, effective January 1, 1998, through the Public Employees' Retirement System. Under no circumstances shall copayments exceed the copayment level established for state employees, effective, January 1, 1998, through the Public Employees' Retirement System. Total annual copayments charged to subscribers shall not exceed two hundred fifty dollars ($250) per family. The board shall instruct participating health plans to work with their provider networks to provide for extended payment plans for subscribers utilizing a significant number of health services for which copayments are charged. The board shall track the number of subscribers who meet the copayment maximum in each year and make adjustments in the amount if a significant number of subscribers reach the copayment maximum.

(b) No deductibles shall be charged to subscribers for health

benefits.

(c) Coverage provided to subscribers shall not contain any preexisting condition exclusion requirements.

(d) No participating health, dental, or vision plan shall exclude any subscriber on the basis of any actual or expected health condition or claims experience of that subscriber or a member of that subscriber's family.

(e) There shall be no variations in rates charged to subscribers including premiums and copayments, on the basis of any actual or expected health condition or claims experience of any subscriber or subscriber's family member. The only variation in rates charged to subscribers, including copayments and premiums, that shall be permitted is that which is expressly authorized by Section 12693.43.

(f) There shall be no copayments for preventive services as defined in Section 1367.35 of the Health and Safety Code.

(g) There shall be no annual or lifetime benefit maximums in any of the coverage provided under the program.

(h) Plans that receive purchasing credits pursuant to Section 12693.39 shall comply with subdivisions (b), (c), (d), (e), (f), and (g).

12693.62. Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services Program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. Participating plans shall refer a child who they reasonably suspect of having a medical condition that is eligible for services under the California Children's Services Program to the California Children's Services Program. The California Children's Services Program shall provide case management and authorization of services if the child is found to be medically eligible for the California Children's Services Program. Diagnosis and treatment services that are authorized by the California Children's Services Program shall be performed by paneled providers for that program and approved special care centers of that program in accordance with treatment plans approved by the California Children's Services Program. All other services provided under the participating plan shall be available to the subscriber.

12693.63. (a) The board shall determine the dental benefits to be provided to subscribers by the program. Such benefits shall be consistent with those provided to state employees through the Department of Personnel Administration on July 1, 1997, except that orthodontia shall only be a benefit when it is determined to be medically necessary.

(b) The board shall establish the required subscriber copayment levels for dental benefits. The copayment levels established by the board shall, to the extent possible, reflect the copayment levels provided to state employees through the Department of Personnel Administration on July 1, 1997, except that no copayment shall be charged for medically necessary orthodontia services. There shall be no subscriber copayments for preventive and diagnostic services, including, but not limited to, examinations, teeth cleaning, X-rays, topical fluoride treatments, space maintainers, and sealants.

(c) No deductible shall be charged to subscribers for dental benefits.

12693.64. Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services Program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating plan shall be available to the subscriber.

12693.65. (a) Vision benefits shall be provided to subscribers and shall meet the federal coverage requirements in Section 2103 of Title XXI of the Social Security Act.

(b) The covered benefits shall be equivalent to those provided to state employees through the Department of Personnel Administration on July 1, 1997.

(c) The board shall establish the required subscriber copayment levels for vision benefits consistent with the limitations of Section 2103 of Title XXI of the Social Security Act. The copayment levels established by the board shall, to the extent possible, reflect the copayment levels provided to state employees through the Department of Personnel Administration on July 1, 1997.

12693.66. Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services Program to be eligible for benefits under the program pursuant to

Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating plan shall be available to the subscriber.

12693.68. The board shall encourage all plans, including those receiving purchasing credits, that provide services under the program to have viable protocols for screening and referring children needing supplemental services outside of the scope of the screening, preventive, and medically necessary and therapeutic services covered by the contract to public programs providing such supplemental services for which they may be eligible, as well as for coordination of care between the plan and the public programs. The public programs for which plans may be required to develop screening, referral, and care coordination protocols may include the California Children's Services Program, the regional centers, county mental health programs, programs administered by the Department of Alcohol and Drug Programs, and programs administered by local education agencies.

12693.69. A child enrolled in the Healthy Families Program who has a medical condition that is eligible for services pursuant to the California Children's Services Program, and whose family is not financially eligible for the California Children's Services Program, shall have the medically necessary treatment services for their California Children's Services Program eligible medical condition authorized and paid for by the California Children's Services Program. County expenditures for the payment of services for the child shall be waived and these expenditures shall be paid for by the state from Title XXI funds that are applicable and state general funds.

12693.70. To be eligible to participate in the program, an applicant shall meet all of the following requirements:

(a) Be an applicant applying on behalf of an eligible child, which means a child who is all of the following:

(1) Less than 19 years of age. An application may be made on behalf of a child not yet born up to three months prior to the expected date of delivery. Coverage shall begin as soon as administratively feasible, as determined by the board, after the board receives notification of the birth. However, no child less than 12 months of age shall be eligible for coverage until 90 days

after the enactment of the Budget Act of 1999.

(2) Not eligible for no-cost full-scope Medi-Cal or Medicare coverage at the time of application.

(3) In compliance with Sections 12693.71 and 12693.72.

(4) A child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, except as specified in Section 12693.76.

(5) A resident of the State of California pursuant to Section 244 of the Government Code; or, if not a resident pursuant to Section 244 of the Government Code, is physically present in California and entered the state with a job commitment or to seek employment, whether or not employed at the time of application to or after acceptance in, the program.

(6) (A) In either of the following:

(i) In a family with an annual or monthly household income equal to or less than 200 percent of the federal poverty level.

(ii) When implemented by the board, subject to subdivision (b) of Section 12693.765 and pursuant to this section, a child under the age of two years who was delivered by a mother enrolled in the Access for Infants and Mothers Program as described in Part 6.3 (commencing with Section 12695). For purposes of this clause, any infant born to a woman whose enrollment in the Access for Infants and Mothers Program begins after June 30, 2004, shall be automatically enrolled in the Healthy Families Program. This enrollment shall cover the first 12 months of the infant's life. At the end of the 12 months, as a condition of continued eligibility, the applicant shall provide income information. The infant shall be disenrolled if the gross annual household income exceeds the income eligibility standard that was in effect in the Access for Infants and Mothers Program at the time the infant's mother became eligible, or following the two-month period established in Section 12693.981 if the infant is eligible for Medi-Cal with no share of cost. At the end of the second year, infants shall again be screened for program eligibility pursuant to this section, with income eligibility evaluated pursuant to clause (i), subparagraphs (B) and (C), and paragraph (2) of subdivision (a).

(B) All income over 200 percent of the federal poverty level but less than or equal to 250 percent of the federal poverty level shall be disregarded in calculating annual or monthly household income.

(C) In a family with an annual or monthly household income greater than 250 percent of the federal poverty level, any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income. If the income deductions reduce the annual or monthly household income to 250 percent or less of the federal poverty level, subparagraph (B) shall

be applied.

(b) If the applicant is applying for the purchasing pool, and does not have a family contribution sponsor the applicant shall pay the first month's family contribution and agree to remain in the program for six months, unless other coverage is obtained and proof of the coverage is provided to the program.

(c) An applicant shall enroll all of the applicant's eligible children in the program.

(d) In filing documentation to meet program eligibility requirements, if the applicant's income documentation cannot be provided, as defined in regulations promulgated by the board, the applicant's signed statement as to the value or amount of income shall be deemed to constitute verification.

(e) An applicant shall pay in full any family contributions owed in arrears for any health, dental, or vision coverage provided by the program within the prior 12 months.

12693.71. (a) The board shall monitor applications to determine whether employers and employees have dropped employer-sponsored dependent coverage in order to participate in the program.

(b) The board may disapprove an application if it is determined that the children to be covered under the application were covered by an employer-sponsored insurance within the last three months.

(c) If the board imposes the limitation identified in subdivision (b) or (d), it shall also establish exceptions to this limitation in cases where prior coverage ended due to reasons unrelated to the availability of the program. This shall include, but not be limited to:

(1) Loss of employment due to factors other than voluntary termination.

(2) Change to a new employer that does not provide an option for dependent coverage.

(3) Change of address so that no employer sponsored coverage is available.

(4) Discontinuation of health benefits to all employees of the applicant's employer.

(5) Expiration of COBRA coverage period.

(6) Coverage provided pursuant to an exemption authorized under subdivision (i) of Section 1367 of the Health and Safety Code.

(d) If the board determines, based on evidence gathered during a reasonable period of program operation, that a substantial share of funds expended for the program are providing health coverage for children that have discontinued employer-based coverage in order to enter the program or if required by the federal government for state plan approval, the board may take actions to increase the three-month time limit specified in subdivision (b), to such a time limit that

cannot exceed six months.

12693.72. (a) The board may disapprove an application if it is determined that the children to be covered under the application were covered by an individual health care service plan contract or individual disability insurance policy during a specified period of time prior to the date of application only if required by the federal government for state plan approval. This time limitation period shall not exceed the time period required by the federal government.

(b) If the board imposes the time limitation identified in subdivision (a), it shall also establish exceptions to this limitation in cases where the prior coverage ended due to reasons unrelated to the availability of the program. This shall include, but not be limited to, the prior coverage being pursuant to a health plan operating pursuant to an exemption authorized by subdivision (i) of Section 1367 of the Health and Safety Code.

12693.73. Notwithstanding any other provision of law, children excluded from coverage under Title XXI of the Social Security Act are not eligible for coverage under the program, except as specified in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 and Section 12693.76.

12693.74. Subscribers shall continue to be eligible for the program for a period of 12 months from the month eligibility is established.

12693.75. (a) The program shall make use of a simple and easy to understand mail-in application process.

(b) For children referred pursuant to Section 14005.41 of the Welfare and Institutions Code, the program shall utilize the school lunch application and any supplemental forms received pursuant to Section 14005.41 of the Welfare and Institutions Code to make an eligibility determination and shall request additional information only as needed to complete the eligibility process.

(c) The Managed Risk Medical Insurance Board may adopt emergency regulations to implement subdivision (b) and coordinate with all other state and local government entities in the implementation of Section 49557.2 of the Education Code and Section 14005.41 of the Welfare and Institutions Code. Any rules and regulations issued by the board pertaining to the implementation of this section may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption and one readoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of

the public peace, health, and safety, or general welfare, and shall be exempt from review by the Office of Administrative Law. Any emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations, and shall remain in effect for not more than 180 days unless the department readopts those regulations. The regulations shall become effective immediately upon filing with the Secretary of State.

12693.755. (a) Subject to subdivision (b), commencing four months after the initial federal approval is obtained pursuant to the waiver described in subdivision (b), the board shall expand eligibility under this part to uninsured parents of, and as defined by the board, adults responsible for, children enrolled to receive coverage under this part or who are enrolled to receive the full scope of Medi-Cal services with no share of cost and whose income does not exceed 250 percent of the federal poverty level, before applying the income disregard provided for in subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70.

(b) (1) The board shall implement a program to provide coverage under this part to any uninsured parent or responsible adult who is eligible pursuant to subdivision (a), pursuant to the waiver identified in paragraph (2).

(2) The program shall be implemented only in accordance with a State Child Health Insurance Program waiver pursuant to Section 1397gg(e)(2)(A) of Title 42 of the United States Code, to provide coverage to uninsured parents and responsible adults, and shall be subject to the terms, conditions, and duration of the waiver. The services shall be provided under the program only if the waiver is approved by the federal Centers for Medicare and Medicaid Services, and, except as provided under the terms and conditions of the waiver, only to the extent that federal financial participation is available and funds are appropriated specifically for this purpose.

12693.76. (a) Notwithstanding any other provision of law, a child who is a qualified alien as defined in Section 1641 of Title 8 of the United States Code Annotated shall not be determined ineligible solely on the basis of his or her date of entry into the United States.

(b) Notwithstanding any other provision of law, subdivision (a) may only be implemented to the extent provided in the annual Budget Act.

(c) Notwithstanding any other provision of law, any uninsured parent or responsible adult who is a qualified alien, as defined in Section 1641 of Title 8 of the United States Code, shall not be determined to be ineligible solely on the basis of his or her date of

entry into the United States.

(d) Notwithstanding any other provision of law, subdivision (c) may only be implemented to the extent of funding provided in the annual Budget Act.

12693.765. (a) Notwithstanding any other provision of law and subject to subdivision (b), a child described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 shall be deemed eligible to participate in the program at birth.

(b) Notwithstanding any other provision of law, subdivision (a) and clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 may only be implemented to the extent that funds are appropriated for that purpose in the annual Budget Act or other statute.

12693.77. (a) The board shall develop safeguards to assure the fiscal integrity of the program.

(b) The program shall ensure that subscribers are not eligible for no-cost full-scope Medi-Cal coverage. The board may provide data on applicants and subscribers to the State Department of Health Services for determination of Medi-Cal eligibility. The State Department of Health Services shall identify those subscribers enrolled in the program who are concurrently enrolled in Medi-Cal with no share of cost.

(c) Any person who intentionally makes false declarations as to his or her eligibility or any person who intentionally makes false declarations as to eligibility on behalf of any other person seeking eligibility under this part for which that person is not eligible shall be guilty of a misdemeanor.

(d) Plans and providers shall be subject to Section 550 of the Penal Code.

(e) Any person who intentionally makes false declarations as to his or her eligibility or any person who intentionally makes false declarations as to eligibility on behalf of any other person seeking eligibility under this part for which that person is not eligible may be denied coverage for up to one year from the date of the denial of coverage by the board.

12693.80. The board shall use due diligence in the creation of participation standards for the program that minimize the incentive for employers or applicants to drop or reduce dependent health coverage.

12693.81. (a) It shall constitute unfair competition for purposes

of Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code for an insurer, an insurance agent or broker, or an administrator, as defined in Section 1759, to refer an individual employee or employee's dependent to the program, or arrange for an individual employee or employee's dependent to apply for the program, for the purpose of separating that employee or employee's dependent from group health coverage in connection with the employee's employment.

(b) Any employee applicant in subdivision (a) shall have personal right of action to enforce subdivision (a).

12693.82. It shall constitute an unfair labor practice contrary to public policy, and enforceable under Section 95 of the Labor Code, for any employer to refer an individual employee or employee's dependent to the program, or to arrange for an individual employee or employee's dependent to apply to the program, for the purpose of separating that employee or employee's dependent from group health coverage provided in connection with the employee's employment.

12693.83. (a) It shall constitute an unfair labor practice contrary to public policy and enforceable under Section 95 of the Labor Code for any employer to change the employee-employer share-of-cost ratio based upon the employee's wage base or job classification or to make any modification of coverage for employees and employee's dependents in order that the employees or employee's dependents enroll in the program established pursuant to this part.

12693.84. For purposes of Sections 12693.82 and 12693.83, group health coverage includes any group disability insurance policy covering hospital, medical, or surgical expenses, group health care service plan contract, or self-insured employee welfare benefit plan.

12693.85. Program decisions described in this section may be appealed to the board. If an applicant believes that a written decision on one of the following specified issues was made in violation of the program statutes or regulations, or other written representation of program policy made to the individual by the program or the board, that individual may file an appeal with the board. Decisions that may be appealed are the following:

(a) A decision that a child is not qualified to participate or continue to participate in the program.

(b) A decision that a child is not eligible for enrollment or continuing enrollment in the program.

(c) A decision as to the effective date of coverage.

12693.86. (a) An appeal shall be filed in writing with the executive director within 60 calendar days of the date of the notice of the decision being appealed.

(b) An appeal shall include all of the following:

(1) A copy of any decision being appealed, or a written statement of the action or failure to act being appealed.

(2) A statement specifically describing the issues that are disputed by the appellant.

(3) A statement specifically describing the program statute or regulation, or other written representation of program policy that the appellant believes the program or board violated.

(4) A statement of the resolution requested by the appellant.

(5) Any other relevant information the appellant wants to include.

(c) Any appeal that does not specifically allege a violation of a program statute or regulation, or other written representation of program policy will be deemed to be a request for program review pursuant to Section 12693.88.

(d) An appeal that specifically alleges a violation of program statute or regulation or other written representation of program policy, but fails to include any other necessary information, shall be returned to the appellant without review. The appellant may resubmit the appeal. The resubmittal shall be filed within the time limits of subdivision (a) or within 20 calendar days of the receipt of the returned appeal, whichever is later.

12693.87. (a) Any appellant who files an appeal pursuant to Section 12693.85 shall receive an initial administrative review of the appeal.

(b) Administrative reviews of appeals shall be conducted in two steps. Each appeal will be reviewed by the program to determine if the requested resolution is required by the statutes and regulations governing the program, or required in order to be consistent with a written representation of program policy made by the program or the board. If so, the appropriate action will be taken within 30 days of the receipt of the appeal, and the appellant will be notified. If not, the appellant will be so notified within 30 days of the receipt of the appeal and informed that he or she may request review by the executive director. This request must be filed in writing with the executive director within 30 days of the date of the notice of the program determination and shall include the information specified in subdivision (b) of Section 12693.86.

(c) In conducting an administrative review of an appeal, the executive director may contact the appellant and any other party for further information.

(d) The executive director's decision shall be in writing.

(e) The appellant retains the right to request an administrative hearing if the appellant is not satisfied with the decision of the executive director. Such a request shall be filed within 30 calendar days of receipt of the executive director's decision. It shall include a clear and concise statement of what action is being appealed, and the reasons the executive director's decision is not correct.

12693.88. In addition to the appeal process established above, the board shall establish a program review process. If a subscriber or purchasing credit member is not eligible to file an appeal pursuant to Section 12693.85, but wants to have any program decision reviewed, he or she may request that the program review the decision. A review pursuant to this section is separate from and independent of an appeal pursuant to Section 12693.85, and a person that files a request pursuant to this section shall not, thereby, gain any right of appeal. Pursuant to Section 12693.49, any dissatisfaction with an action of a participating health, vision, or dental plan shall be resolved with the plan rather than by requesting program review. When an appeal that requests an administrative hearing is received, the appeal shall be set for hearing as provided in Section 12693.89.

12693.89. (a) Administrative hearings of appeals shall be conducted according to the appeal procedures, including pre- and post-hearing procedures, set forth in Article 3 (commencing with Section 1140) of Chapter 2 of Division 2 of Title 1 of the California Code of Regulations. Article 3 (commencing with Section 1140) is hereby incorporated by reference, subject to the following modifications:

(1) Reference to the Health and Welfare Agency or the component department shall be deemed reference to the Managed Risk Medical Insurance Board.

(2) Reference to the private nonprofit human service organization shall be deemed reference to the appellant.

(3) Reference to Health and Safety Code sections providing the bases, grounds, authorization, or procedures for appeals shall be deemed reference to the bases and authorization, for appeal found in Section 12693.85 and the appeal procedures found in this section.

(4) The 30-day time period specified in subdivision (b) of Section 1140 of Title 1 of the California Code of Regulations shall be extended to 60 days, and the 10-day time period in subdivision (a) of Section 1141 of Title 1 of the California Code of Regulations shall be extended to 30 days.

(5) If the proposed decision submitted to the board is not adopted as the decision, the board may itself decide the case on the record, or may refer the case to the same hearing officer to take additional evidence. If the case is referred back to the hearing officer, the

hearing officer shall prepare a new proposed decision based on the additional evidence and the record of the prior hearing.

(6) The decision of the board shall be issued within 90 days following the initial hearing or, if the case is referred back to the hearing officer, within 90 days of the second hearing.

(b) The board may elect to have a hearing conducted by an Administrative Law Judge employed by the Office of Administrative Hearings pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

12693.90. (a) The board shall appoint a 15-member advisory panel to advise the board, the chair of which may serve as an ex officio, nonvoting member of the board. The panel shall be appointed and ready to perform its duties by no later than February 1, 1998.

(b) The membership of the advisory panel shall be composed of all of the following:

(1) Three representatives from the subscriber population.

(2) One physician and surgeon who is board certified in pediatrics.

(3) One physician and surgeon who is board certified in the area of family practice medicine.

(4) One member who is a licensed, practicing dentist.

(5) One representative from a licensed nonprofit primary care clinic.

(6) One representative from a licensed hospital that is on the disproportionate share list maintained by the State Department of Health Services.

(7) One representative of the mental health provider community.

(8) One representative of the substance abuse provider community.

(9) One representative of the county public health provider community.

(10) One representative from the education community.

(11) One representative from the health plan community.

(12) One representative from the business community.

(13) One representative from an eligible family with children with special needs.

(c) The advisory board members shall have demonstrated expertise in the provision of health-related services to children aged 18 years and under, as applicable.

(d) The advisory board members shall be composed of representatives of the geographic, cultural, economic, and other social factors of the state.

(e) The panel shall elect, from among its members, its chair.

(f) The panel shall have all of the following powers and duties:

(1) To advise the board on all policies, regulations, operations, and implementation of the program.

(2) To consider all written recommendations of the panel and respond in writing when the board rejects the advice of the panel.

(3) To meet at least quarterly, unless deemed unnecessary by the chair.

(g) The members of the panel shall be reimbursed for all necessary travel expenses associated with the activities of the panel.

(h) The members of the panel who represent the subscriber population may receive per diem compensation if they are otherwise economically unable to meet panel responsibilities.

12693.91. (a) The State Department of Health Services, in conjunction with the Managed Risk Medical Insurance Board, the County Medical Services Program board, and the Rural Health Policy Council, may develop and administer up to five demonstration projects in rural areas that are likely to contain a significant level of uninsured children, including seasonal and migratory worker dependents. In addition to any other funds provided pursuant to this section the grants for demonstration projects may include funds pursuant to subdivision (d).

(b) The purpose of the demonstration projects shall be to fund rural collaborative health care networks to alleviate unique problems of access to health care in rural areas.

(c) The State Department of Health Services, in conjunction with the Managed Risk Medical Insurance Board and Rural Health Policy Council, shall establish the criteria and standards for eligibility to be used in requests for proposals or requests for application, the application review process, determining the maximum amount and number of grants to be awarded, preference and priority of projects, and compliance monitoring after receiving comment from the public.

(d) The grants may include funds for purchasing equipment, making capital expenditures, and providing infrastructure, including, but not limited to, salaries and payment of leaseholds. The funds under this subdivision may only be awarded to qualified eligible health care entities as determined by the State Department of Health Services. Title to any equipment or capital improvement purchased or acquired with grant funds shall vest in the grantee for the public good and not the state. Capital expenditures shall not include the acquisition of land. Notwithstanding subdivision (e), this subdivision shall be implemented only when funds are appropriated in the annual Budget Act or another statute to fund the cost of implementing this subdivision.

(e) This section shall only become operative upon federal approval of the state plan or subsequent amendments for the program and approval of federal financial participation

12693.915. (a) It is the intent of the Legislature to utilize fiscal resources in the most prudent and cost-efficient manner and to maximize the use of federal funds for services when feasible. Therefore, the Legislature intends to access funds from the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund created in Section 30122 of the Revenue and Taxation Code, and as appropriated in the annual Budget Act, and to use these funds to obtain a 65-percent federal match through California's allocation from the State Children's Health Insurance Program (SCHIP). These funds will then be used under the state's Healthy Families Program specifically for the rural demonstration projects established in Section 12693.91.

(b) Notwithstanding Section 30122 of the Revenue and Taxation Code, funding for the rural demonstration projects as provided under the Health Families Program may be made available from the funds appropriated from the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund and from funding received pursuant to Title XXI of the federal Social Security Act. These funds shall be used as provided under Section 12693.91.

(c) Subdivision (b) constitutes an amendment of the Tobacco Tax and Health Protection Act of 1988, as added by Proposition 99.

12693.92. (a) The program shall prepare an annual report in conformance with the requirements of Section 2108 of Title XXI of the Social Security Act (P.L. 105-33). A copy of the report shall be provided to the Legislature and other interested parties.

(b) As soon as possible, but no later than July 1, 2000, the board shall include in its annual report information on (1) how assurance of preventive services by health plans and health care providers is achieved; (2) the performance of health plans and providers in providing preventive services and addressing barriers to service delivery; and (3) the mechanism or mechanisms that will be used to identify changes over time in the health status of children enrolled in the program. Beginning no later than July 1, 2001, the report shall include information about changes in the health status of children participating in the program.

(c) The board shall immediately provide the fiscal and policy committees of the Legislature with a copy of their submittal to the federal government to meet the requirements for state plan provisions as contained in Chapter 1 of Title XXI of the Social Security Act. Any and all subsequent amendments to the state plan shall also be provided accordingly.

12693.925. (a) The Managed Risk Medical Insurance Board shall report to the Legislature on or before January 30, 2004, the following information with respect to the State Children's Health Insurance Program:

(1) A list of the categories of vulnerable children who should be the targets of public health initiatives, including, but not limited to, immigrant children, homeless children, and other children that face health disparities.

(2) Recommendations on innovative methods available under the federal program for addressing health needs and barriers to care for the identified groups of vulnerable children. The board shall report as many recommendations as possible that are available under the federal program and the expected impact of each recommendation.

(3) Recommendations on innovative methods available under the federal program for developing in urban areas initiatives similar to the rural demonstration projects. The board shall report as many recommendations as possible that are available under the federal program and the expected impact of each recommendation.

(b) The board shall seek input, at regularly scheduled meetings of the board, from the Healthy Families Advisory Panel and stakeholder organizations, including, but not limited to, organizations that represent immigrant and homeless populations, other communities that experience health disparities, and traditional providers of care to low-income populations.

(c) This section shall be implemented only to the extent that federal financial participation is obtained.

12693.93. The board shall prepare an evaluation of the program and other state efforts to expand coverage to children in conformance with Section 2108 of Title XXI of the Social Security Act. The evaluation shall incorporate measurement of the delivery of preventive services by health plans and health care providers and assessment of changes over time in the health status of children participating in the program.

12693.95. (a) The board in consultation with the Department of Alcohol and Drug Programs shall provide the Legislature by April 15, 1998, a proposal assessing the viability of providing additional drug and alcohol treatment services for children enrolled in the program.

If the board determines that it is feasible to provide additional federal funds received pursuant to Title XXI (commencing with Section 2101) of the Social Security Act to counties to finance drug and alcohol services and required federal approval is obtained, the board shall negotiate with participating health plans to establish memoranda of understanding between plans and counties to facilitate

referral of children in need of these services.

(b) Based on the April 15, 1998, report by the board to the Legislature, the Legislature finds and declares that there is a statewide gap in publicly funded alcohol and other drug treatment for adolescents which is significant and systemic.

(1) Therefore, the Department of Alcohol and Drug Programs, in cooperation with the board, shall do the following:

(A) Review capacity needs for the Healthy Families Program target group after year one data has been collected and an assessment of the adequacy of the benefit can be made.

(B) Request that counties provide data on the number of adolescents requesting alcohol and other drug treatment and whether they are participating in the Healthy Families Program.

(2) The board shall do the following:

(A) Request the participating health plans to voluntarily collect data, as prescribed by the board, on the number of children needing services that exceed the substance abuse benefit in their plan.

(B) Upon contract renewal, require participating health plans to collect and report the data.

(C) By September 1, 1999, provide the policy and fiscal committees of the Legislature with an analysis of the data obtained by the Department of Alcohol and Drug Programs and from the participating health plans.

12693.96. (a) There is hereby created in the State Treasury the Healthy Families Fund which is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the board for the purposes specified in this part.

(b) The board shall authorize the expenditure from the fund of any state funds, federal funds, or family contributions deposited into the fund. This shall include the authority for the board to authorize the State Department of Health Services to transfer funds appropriated to the department for the program to the Healthy Families Fund, and to also deposit those funds in, and to disburse those funds from, the Healthy Families Fund.

(c) Notwithstanding any other provision of law, this part shall be implemented only if, and to the extent that, as provided under Title XXI of the Social Security Act, federal financial participation is available and state plan approval is obtained, except as specified in Section 12693.76.

(d) Nothing in this part is intended to establish an entitlement for individual coverage.

12693.97. The State Department of Health Services and the board may explore and utilize any options available under federal law to allow the use of charitable funding as a match for federal funds for use

in the provision of coverage by private and public not-for-profit organizations consistent with the provisions of this part.

12693.98. (a) (1) The Medi-Cal-to-Healthy Families Bridge Benefits Program is hereby established to provide any child who meets the criteria set forth in subdivision (b) with a one calendar-month period of health care benefits in order to provide the child with an opportunity to apply for the Healthy Families Program established under Chapter 16 (commencing with Section 12693).

(2) The Medi-Cal-to-Healthy Families Bridge Benefits Program shall be administered by the board.

(b) (1) Any child who meets all of the following requirements shall be eligible for one calendar month of Healthy Families benefits funded by Title XXI of the Social Security Act, known as the State Children's Health Insurance Program:

(A) He or she has been receiving, but is no longer eligible for, full-scope Medi-Cal benefits without a share of cost.

(B) He or she is eligible for full-scope Medi-Cal benefits with a share of cost.

(C) He or she is under 19 years of age at the time he or she is no longer eligible for full-scope Medi-Cal benefits without a share of cost.

(D) He or she has family income at or below 200 percent of the federal poverty level.

(E) He or she is not otherwise excluded under the definition of targeted low-income child under subsections (b)(1)(B)(ii), (b)(1)(C), and (b)(2) of Section 2110 of the Social Security Act (42 U.S.C. Secs. 1397jj(b)(1)(B)(ii), 1397jj(b)(1)(C), and 1397jj(b)(2)).

(2) The one calendar month of benefits under this chapter shall begin on the first day of the month following the last day of the receipt of benefits without a share of cost.

(c) The income methodology for determining a child's family income, as required by paragraph (1) of subdivision (b) shall be the same methodology used in determining a child's eligibility for the full scope of Medi-Cal benefits.

(d) The one calendar-month period of Healthy Families benefits provided under this chapter shall be identical to the scope of benefits that the child was receiving under the Medi-Cal program without a share of cost.

(e) The one calendar-month period of Healthy Families benefits provided under this chapter shall only be made available through a Medi-Cal provider or under a Medi-Cal managed care arrangement or contract.

(f) Except as provided in subdivision (j), nothing in this section shall be construed to provide Healthy Families benefits for more than a one calendar-month period under any circumstances, including

the failure to apply for benefits under the Healthy Families Program or the failure to be made aware of the availability of the Healthy Families Program, unless the circumstances described in subdivision (b) reoccur.

(g) (1) This section shall become operative on the first day of the second month following the effective date of this section, subject to paragraph (2).

(2) Under no circumstances shall this section become operative until, and shall be implemented only to the extent that, all necessary federal approvals, including approval of any amendments to the State Child Health Plan have been sought and obtained and federal financial participation under the federal State Children's Health Insurance Program, as set forth in Title XXI of the Social Security Act, has been approved.

(h) This section shall become inoperative if an unappealable court decision or judgment determines that any of the following apply:

(1) The provisions of this section are unconstitutional under the United States Constitution or the California Constitution.

(2) The provisions of this section do not comply with the State Children's Health Insurance Program, as set forth in Title XXI of the Social Security Act.

(3) The provisions of this section require that the health care benefits provided pursuant to this section are required to be furnished for more than two calendar months.

(i) If the State Child Health Insurance Program waiver described in Section 12693.755 is approved, and at the time the waiver is implemented, the benefits described in this section shall also be available to persons who meet the eligibility requirements of the program and are parents of, or, as defined by the board, adults responsible for, children enrolled to receive coverage under this part or enrolled to receive full scope Medi-Cal services with no share of cost.

(j) The one month of benefits provided in this section shall be increased to two months commencing on implementation of the waiver referred to in Section 12693.755.

12693.981. (a) (1) The Healthy Families-to-Medi-Cal Bridge Benefits Program is hereby established to provide any person enrolled for coverage under this part who meets the criteria set forth in subdivision (b) with a two calendar-month period of health care benefits in order to provide the person with an opportunity to apply for Medi-Cal.

(2) The Healthy Families-to-Medi-Cal Bridge Benefits Program shall be administered by the board.

(b) (1) Any person who meets all of the following requirements shall be eligible for two additional calendar months of Healthy

Families benefits:

(A) He or she has been receiving, but is no longer eligible for, benefits under the program.

(B) He or she appears to be income eligible for full-scope Medi-Cal benefits without a share of cost.

(2) The two additional calendar months of benefits under this chapter shall begin on the first day of the month following the last day of the person's eligibility for benefits under the program.

(c) The two-calendar-month period of Healthy Families benefits provided under this chapter shall be identical to the scope of benefits that the person was receiving under the program.

(d) Nothing in this section shall be construed to provide Healthy Families benefits for more than a two calendar-month period under any circumstances, including the failure to apply for benefits under the Medi-Cal program or the failure to be made aware of the availability of the Medi-Cal program unless the circumstances described in subdivision (b) reoccur.

(e) This section shall become inoperative if an unappealable court decision or judgment determines that any of the following apply:

(1) The provisions of this section are unconstitutional under the United States Constitution or the California Constitution.

(2) The provisions of this section do not comply with the State Children's Health Insurance Program, as set forth in Title XXI of the federal Social Security Act.

(3) The provisions of this section require that the health care benefits provided pursuant to this section are required to be furnished for more than two calendar months.

12693.982. For purposes of this chapter, "Medi-Cal" means the state health care program established pursuant to Chapter 14 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.